



## COPD Management Plan – CCG Implementation Aid

Prescribing considerations	
<p><b>Why was the GMMMG COPD management plan developed?</b></p> <p><b>To address the following issues:</b></p> <ul style="list-style-type: none"> <li>➤ Multitude of different inhalers and inhaler types<sup>1</sup></li> <li>➤ Probable overprescribing of inhaled corticosteroids<sup>2</sup></li> <li>➤ Variation between CCGs in admission rates and spend on respiratory drugs<sup>3</sup></li> <li>➤ In patients with COPD, there is poor correlation between symptoms, FEV1 and exacerbations<sup>4</sup></li> </ul> <p><b>Why is this important?</b></p> <ul style="list-style-type: none"> <li>➤ Inhalers have to be used correctly and consistently or the benefits expected from medications will not be realised<sup>8</sup></li> <li>➤ High dose inhaled corticosteroids are associated with serious side effects<sup>2</sup></li> </ul>	<p><b>What would good practice look like?</b></p> <ul style="list-style-type: none"> <li>➤ Smoking cessation advice given at every opportunity (if applicable)<sup>5</sup></li> <li>➤ Patients are reviewed at appropriate intervals, including inhaler technique<sup>6</sup></li> <li>➤ Patients have inhalers of similar type (as use of different types is associated with more errors<sup>7</sup>)</li> <li>➤ Inhaled corticosteroids may be withdrawn in patients at low risk of exacerbation.<sup>4</sup></li> </ul> <p><b>What outcomes should I be measuring?</b></p> <ul style="list-style-type: none"> <li>➤ Any change in corticosteroid prescribing</li> <li>➤ Any change in exacerbations of COPD</li> <li>➤ Any change in COPD referral or admission rates</li> </ul>
<p><b>Prescriber action points:</b></p> <ul style="list-style-type: none"> <li>➤ Ensure familiarity with the choice of inhalers within the management plan, and be able to demonstrate their use to patients correctly</li> <li>➤ Be aware of the spacers that are appropriate for use</li> <li>➤ Check inhaler technique</li> <li>➤ Ensure reviews take place at appropriate intervals</li> <li>➤ Ensure patients are referred to specialist services when necessary</li> </ul>	

A framework for decision making	
<p><b>Efficacy</b></p> <ul style="list-style-type: none"> <li>➤ All inhaled steroids are of equal efficacy</li> <li>➤ All inhaled LAMAs are probably of equal efficacy. There may be minor differences in speed of onset.</li> <li>➤ There is some evidence that indacaterol is better than other LABAs at reducing exacerbation rates and improving breathlessness<sup>9</sup></li> <li>➤ Dual bronchodilator therapy improves patient reported dyspnoea and lung function compared to placebo and single bronchodilators (references provided with management plan)</li> </ul>	<p><b>Safety</b></p> <ul style="list-style-type: none"> <li>➤ High dose inhaled corticosteroids are associated with serious side effects</li> <li>➤ Inhaled steroids increase the risk of pneumonia in COPD patients<sup>10</sup></li> <li>➤ Prescribe by BRAND and DEVICE</li> </ul>
<p><b>Cost</b></p> <ul style="list-style-type: none"> <li>➤ An inhaler guide has been produced to support the management plan which includes prices<sup>11</sup></li> </ul>	<p><b>Patient factors</b></p> <ul style="list-style-type: none"> <li>➤ Options are once or twice daily</li> <li>➤ Preferred option once daily</li> <li>➤ Different inhaler devices to support different levels of dexterity; aim to be consistent with types e.g. all DPI, all MDI.</li> <li>➤ Dual bronchodilator therapy reduces exacerbations compared to monotherapy<sup>12</sup></li> <li>➤ A trial of a LABA–LAMA regimen of indacaterol–glycopyrronium showed not only non-inferiority but also superiority to the LABA–inhaled glucocorticoid regimen of salmeterol–fluticasone in reducing the rate of exacerbations<sup>13</sup></li> </ul>

## References

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